CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 1 (2-Page Format)

45657

Shade Circles Like This--> ●
Not Like This--> ⊗ ✓

This page may be completed by potential vaccine recipient

1. Today's Date (M M / D D / Y Y Y Y) ☐☐ / ☐☐ / ☐☐☐☐

2a.GENDER ○ Male ○ Female 2b. First day of last normal menstrual period: ___ / ___ / _____

2c. FEMALES: Was your last menstrual period normal and on time? ○ Yes ○ No ○ Unsure

2d. Are you currently breastfeeding? ○ Yes ○ No

3. Could someone you LIVE WITH or YOU be pregnant? ○ Yes ○ No ○ Unsure

4. Do you have a child in the home less than one year of age? ○ Yes ○ No ○ Unsure

5. Did you ever receive smallpox vaccine? ○ Yes ○ No ○ Unsure

5a. IF YES: Were you vaccinated within the last 10 years? ○ Yes ○ No ○ Unsure

5b. IF UNSURE: Birth Year ☐☐☐☐ First Year in Military (if applicable) ☐☐☐☐

6. Have you ever had a serious problem after smallpox or other vaccination? (Describe below) ○ Yes ○ No ○ Unsure

7. Do you currently have an illness with fever? ○ Yes ○ No ○ Unsure

8. Do you have a heart or vessel condition, such as angina, earlier heart attack, coronary artery disease, congestive heart failure, cardiomyopathy, stroke, "mini stroke," chest pain or trouble breathing on exertion? ○ Yes ○ No ○ Unsure

9. Check EACH of the following conditions that apply to you:
☐ Heart Condition before age 50 in mother, father, brother, sister
☐ Smoke cigarettes now ☐ High blood pressure ☐ High cholesterol ☐ Diabetes or high blood sugar

10. Are you allergic to any of these products: tetracycline, streptomycin, polymyxin B, neomycin, latex? ○ Yes ○ No ○ Unsure

11. Do you NOW HAVE or have you EVER HAD Eczema or Atopic Dermatitis? (Usually this skin condition involves an itchy, red, scaly rash that lasts more than 2 weeks. It often comes and goes.) ○ Yes ○ No ○ Unsure

12. Do you NOW HAVE any of the following skin problems: Psoriasis (scaly skin rash), Burns (other than mild sunburn), Impetigo (skin infection), Uncontrolled Acne, Shingles (herpes zoster), Chickenpox, Darier's disease, Other Skin Condition (Describe below)? ○ Yes ○ No ○ Unsure

13. Do you have a problem or take a medication that affects the immune system? For example, do you ○ Yes ○ No ○ Unsure
have or take medication for HIV, AIDS, leukemia, lymphoma, or chronic liver problem;
have or take medication for Crohn's disease, lupus, arthritis, or other immune disease;
have had radiation or X-ray treatment (not routine X-rays) within the last 3 months;
have EVER had a bone-marrow or organ transplant (or take medication for that); or
have another problem that requires steroids, prednisone or a cancer drug for treatment.

14. Are you currently being treated with steroid eye drops or ointment, or have you had recent eye surgery? ○ Yes ○ No ○ Unsure

15. Do you LIVE WITH anyone who NOW HAS or EVER HAD Eczema or Atopic Dermatitis? (Usually this skin condition involves an itchy, red, scaly rash that lasts more than 2 weeks. It often comes and goes.) ○ Yes ○ No ○ Unsure

16. Do you LIVE WITH anyone who NOW HAS any of the following skin problems: Psoriasis (scaly skin rash), Burns (other than mild sunburn), Impetigo (skin infection), Uncontrolled Acne, Shingles (herpes zoster), Chickenpox, Darier's disease, Other Skin Condition (Describe below)? ○ Yes ○ No ○ Unsure

17. Do you LIVE WITH someone who has a problem or takes a medication that affects the immune system? ○ Yes ○ No ○ Unsure
For example do you have a close household contact who
has or takes medication for HIV, AIDS, leukemia, lymphoma, or chronic liver problem;
has or takes medication for Crohn's disease, lupus, arthritis, or other immune disease;
has had radiation or X-ray treatment (not routine X-rays) within the last 3 months;
has EVER had a bone-marrow or organ transplant (or take medication for that); or
has another problem that requires steroids, prednisone or a cancer drug for treatment.

18. Do you have other questions or have other concerns you would like to discuss? ○ Yes ○ No

NOTE: If you think you might have one of the many risk factors for HIV infection, we can arrange for HIV testing before vaccination.
FOR FEMALES: If you might be pregnant, or likely to become pregnant, please tell us. You may need additional pregnancy testing.

Explain "other," "unsure" or additional concerns (may use additional page)

Last Name

First Name MI

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Patient's Identification (May use for mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(or FMP)
ORGANIZATION
STATUS
DEPT/SVC

45657

CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 2 (2-Page Format)

This page to be completed by a health care provider

1. Provider Assessment Date (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

If Provider Assessment Date or Action Taken Immunization Date is blank, Default is "Today's date" on page 1.

2. Reason for Vaccination (Indicate One):

- ○ Pre-outbreak: disease prevention
- ○ Post-outbreak: not exposed to virus
- ○ Post-outbreak: exposed to virus
- ○ Other reason (Describe)

3. Vaccine Risk Factors based on page 1 review and interview (Check all that apply):

	Self	Close Contact
No restriction	○	○
Pregnancy	○	○
Immune supression	○	○
Skin condition	○	○
Relevant allergy	○	
Heart condition	○	
Unsure	○	

3+ RF ○

○ (Describe)

4. Provider comment on any concerns about contraindications, need to defer, need to consult, and/or relevent diagnosis

5. Provider Decision and Plan (Check all that apply):

- ☐ Vaccinate: Primary (e.g. birth year>1972, military entry >1984)
- ☐ Vaccinate: Revaccination
- ☐ Medically immune: vaccinated within approp interval (MI)
- ☐ Vaccination deferred: Pending consult or lab test
- ☐ Vaccination deferred: Temporary contraindication (MT)
- ☐ Vaccination contraindicated unless exposed (MP)
- ☐ Vaccination not given (other reason specify below):

6. IF NOT IMMUNIZED, Check all that apply:

- ☐ Reason for non-immunization explained
- ☐ Lab test requested
- ☐ Consult request written/sent
- ☐ Follow up appointment planned
- ☐ Other reason (specify below):

List labs or consults requested, and length of temp referrals

Provider Signature and Printed Name/Stamp:

VACCINE ADMINISTRATION:

Vaccination Date (M M / D D / Y Y Y Y)

7. Vaccination Action Taken: ☐☐ / ☐☐ / ☐☐☐☐

Location: ○ Left Arm ○ Right Arm ○ Other location (describe)

Number of Jabs: ☐☐

Lot # ☐☐☐☐☐☐☐ Mfr ☐☐☐

For QA use: local vial serial # ☐☐☐

8. IF IMMUNIZED, Check all that apply:

- ☐ Information sheet given to recipient
- ☐ Recipient advised about post-vaccination reaction and care
- ☐ Reasons for follow-up clinic visit described
- ☐ Patient understands information given
- ☐ Bandages provided if needed

Please assure that all actions taken and deferrals are updated into your service's electronic Immunization Tracking System (ITS) as soon as possible.

Vaccine administered by: (Signature and Printed Name/Stamp)

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Patient's Identification (May use for mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
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